ies may cause epileptiform attacks if there is basilar thrombosis or analogous lesions of the circulus arteriosus Willisii. Cancato thinks that this phenomenon can be utilized for making the diagnosis of endarteritis of the cerebral arteries, as he could elicit it in ten individuals presenting arterio-sclerosis while this compression of the carotid arteries remained without effect in ten (evidently healthy) men between the ages of 23 and 25. Naunyn reports three cases in all of which he was able to call forth epileptic attacks by compression of the carotid arteries. Two cases and probably also the third concern senile individuals (65 to 70 years). One suffered from attacks of vertigo. The second one had typical epileptic seizures, which had come on at the age of about 53 years. In all three patients there was marked arterio-sclerosis. In case 3 the compression of the carotid arteries had evil effect (not given in detail since the report of this case is left out, evidently by some mistake), and the post-mortem examination in this case showed that all arteries of the base of the brain were healthy previously.

The observations made lead N. to the following conclusions:

1. The compression of the carotid arteries may prove dangerous and ought therefore not to be made use of for diagnostic purposes.

2. It is true that compression of the carotid arteries may call forth epileptiform attacks if there is thrombosis of the basilar arteries or some analogous lesion of the circulus arteriosus Willisii; but this compression can also give rise to similar paroxysms, when the arterial circulation of the brain is disturbed by a *general condition* such as valvular insufficiency, diminution of the energy of the heart and generalized arterio-sclerosis. Accordingly the phenomenon described (Griesinger's symptom) has no such definite diagnostic value with regard to the condition of the cerebral arteries as Cancato ascribes to it.

ONUF.

EPILEPTIC AURAS.

M. J. Durand (Thése de Paris, 1896) makes a provisional classification of auras. He finds that an aura is present in 71 per cent. of epileptics, and is a little more frequent in woman than in man. It is constant, when it exists at all, in 92.9 per cent., invariable in 91.5 per cent., simple in 52 per cent. and complex in 48 per cent. The aura must be considered as having a central origin. Its localization will sometimes serve to indicate the site of the epileptogenic lesion. Attempts to control the occurence of the fits by interrupting the course of the aura have given very uncertain results; however, the presence of a constant and invariable aura at least renders the prognosis of epilepsy less bad, and sometimes, if the warning be sufficiently long, will allow him to follow his ordinary course of life. MITCHELL.

EPILEPTIC AMNESIA.

M. Seglas (Sociétê de Méd. Legale; Séance, March 9, 1897) reports two observations upon retro-active amnesia in epilepsy, which are particularly interesting as both of the cases were pure epilepsy; alcohol, traumatism and other etiological factors could be entirely excluded.

The first patient was a man, 28 years of age, with bad family history, but personally well until 14 years of age, when he had his first epileptic attack. No return took place until he was 23 years of age, when the attacks occurred about once a month without being accompanied with any unusual symptoms. At one time at table he wounded himself with a knife during an attack. Upon recovery of consciousness, and afterward, he was unable to remember anything which had occurred during the morning of that day.

The second example was a patient at the Salpétrière, 40 years of age, who had been the subject of epilepsy for five years. The attacks were mild so far as motor manifestations were concerned, but the condition of semi-consciousness persisted for a quarter of an hour. Upon his recovery, and afterwards, he was unable to recall anything which had happened during the attack and for some hours preceding the paroxysm.

The author makes clear the distinction between these retrograde amnesias and the cases where the crisis is preceded by vertigo or delirium; and there should also be a distinction from the post epileptic confusion, which are so common in cases in which alcohol and traumatism play a part.

The medico-legal aspect of this state of forgetfulness is of obvious importance. MITCHELL.

Gaz. Hebd. de Méd. et de Chie., March 18, 1897:

THE TENDON REFLEXES IN THE POST EPILEPTIC STATE.

G. Pieraccini in studying the behavior of the tendon reflexes during and after epileptic convulsions, came to the following results: Immediately after a convulsive attack in the period of coma, the tendon reflexes are almost abolished, or at least decidedly diminished. After an interval of 5 minutes to half an hour they reappear, feeble at first, then slowly increase until the patient is completely over the attack when the reflexes are found slightly increased. The diminution of the reflexes is proportional to the duration and intensity of the attack. In even lateral convulsions the abolition of the reflexes is limited to the affected side. —Settmana Med. dello Sperimenale, No. 32, 1896. W. C. K.

CONSTANT SIGNS OF EPILEPSY.

MM. Mairet and Vires read before the Academie de Médecine (Medical Week, Feb. 5, 1897), a paper on epilepsy, in which the authors say it has been their endeavor to find constant signs of that disease, whose existence would permit of the certain diagnosis of the epileptic nature of an attack, whether of convulsive or larval epilepsy. This is especially important since epilepsy of the convulsive form may be simulated so well as to make it difficult for the most careful examination to detect the imposition. The authors from study of a large number of cases have reached the following conclusions:

Even a single attack of epilepsy is associated with an increase in the nitrogen and phosphates excreted.

The course of the general temperature is characteristic. being lower than normal during the convulsive period and during or following sleep, with an increase upon awakening and a gradual rise to the normal. The urine is hypotoxic after the attack.

During the periods between the paroxysms the urine is hypotoxic also. The fatal dose of the urine of a healthy person varies between 45 and 80 cubic centimetres, whereas that of the epileptic is between 150 and 250 cubic centimetres.

The urine of larval epilepsy is constantly hypotoxic, the fatal dose ranging between 150 and 480 cubic centimetres.

This constant hypotoxicity in epilepsy is therefore an important, permanent sign from a medico-legal point of view, especially as it may be utilized for a diagnosis of the obscure larval form of epilepsy.

J. K. MITCHELL.

PSYCHIATRY.

ESSENTIAL ACROPHOBIA.

Acrophobia (fear of high places) in a degree scarcely to be designated as pathological, is very frequent in nervous and timid people. As a marked or prominent symptom in the more pronounced cases of neurasthenia it is far from rare, but entirely dissociated from other nervous manifestations it is very uncommon.

Gelieanu (Jour. de Méd. de Paris, Oct. 4, 1896) reports such a case